MDR Tracking Number: M5-04-0919-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 11-26-03.

The IRO reviewed manual therapy, therapeutic exercises, and mechanical traction from 9-11-03 through 9-30-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 2-9-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
9-11-03	99213 97140 97110 97012	$66.19 $34.05 $136.20 $17.15	$0.00	No EOB	$68.24 $27.30 x 125% = $34.13 $15.37 x 125% = $19.21	Medicare Rule 134.202	Since neither party submitted an EOB, this review will be per Rule 134.202. Relevant information supports delivery of service for 99213, 97140, and 97012. Recommend reimbursement of $66.19 + $34.05 + $17.15 = $117.39. 97110: See RATIONALE below.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
9-18-03	99213 97140 97110 97012	$66.19 $34.05 $136.20 $17.15					Same as above. Recommend reimbursement of $66.19 + $34.05 + $17.15 = $117.39. 97110: See RATIONALE below.
9-15-03 9-16-03 9-22-03 9-23-03 9-24-03 9-25-03 9-29-03 9-30-03	99213	$66.19 x 8 days	$0.00	G	$54.59 x 125% = $68.24	Medicare Rule 134.202	Office visits are not global to any other service. Relevant information supports delivery of service. Recommend reimbursement of $66.19 x 8 days = $529.52.
TOTAL		$866.20					The requestor is entitled to reimbursement of $764.30.

RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

The above Findings and Decision are hereby issued this 12th day of May 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 9-11-03 through 9-30-03 in this dispute.

This Order is hereby issued this 12th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

February 9, 2004

NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter

RE: MDR Tracking #: M5-04-0919-01

___has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___for independent review in accordance with this Rule.

___has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___for independent review. In addition, the ___chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a female who sustained a work related injury on ___. The patient reported that while at work she injured her back when she attempted to lift a heavy object from the floor. On 9/5/03 the patient was evaluated for treatment and underwent lumbar spine X-Rays that showed no evidence of fracture or dislocation. The patient was referred for an MRI and the initial diagnoses for this patient were intervertebral disc disorder with myelopathy, lumbar region, nerve root compression, lumbar, and lumbar sprain. A MRI of the lumbar spine dated 9/17/03 showed L5-S1 3mm posterior central left parasagittal disc herniation impacting on and somewhat compressing the left anterior aspect of the thecal sac. An EMG performed on 10/17/03 indicated no electrophysiological evidence of lumbar radiculopathy, lumbosacral plexopathy, or distal mononeuropathy. Treatment for this patient's condition has included joint mobilization, spinal traction, myofascial release, TENS unit and therapeutic exercises.

Requested Services
Manual therapy, therapeutic exercises, mechanical traction therapy from 9/11/03 through 9/30/03

Decision
The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision
The ___chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her back on ___. The ___chiropractor reviewer also noted that the diagnoses for this patient included intervertebral disc disorder with myelopathy, lumbar region, nerve root compression, lumbar and lumbar sprain. The ___chiropractor reviewer further noted that treatment for this patient's condition has included joint mobilization, spinal traction, myofascial release, TENS unit and therapeutic exercises. The ___chiropractor reviewer indicated that the patient received ten sessions of physical therapy that included manual therapy, therapeutic exercises and mechanical traction therapy. The ___chiropractor reviewer explained that the number of visits were within the American Association of Orthopedic Surgeons guidelines for low back pain treatment as well as the Medicare guidelines for physical therapy. Therefore, the ___chiropractor consultant concluded that the Manual therapy, therapeutic exercises, mechanical traction therapy from 9/11/03 through 9/30/03 were medically necessary to treat this patient's condition. (American Association of Orthopedic Surgeons; Low Back Pain Guidelines: 1996)

Sincerely,